Dear Member

Negotiations for the fifth multi-employer collective agreement (MECA) covering ASMS members employed by the 20 DHBs commenced on 5-6 May in Wellington. Bargaining Bulletin is an ASMS publication sent to all DHB employed members to report on these negotiations.

Further negotiations have been scheduled for 20 May, 26 May, 2-3 June and 14-15 July in Wellington. The DHBs have expressed a view that a settlement (subject to ratification) should be achievable by mid-July. Time will tell, and certainly there will be no settlement on the DHBs’ terms. If no provisional settlement is reached, then further dates will be scheduled.

The negotiating teams

ASMS

The ASMS negotiation team is the largest ever (29) but even with this number we were not able to cover all DHBs. In addition to the National Executive, we have included several branch presidents but also sought to have a better gender balance and include medical officers.

The team comprises:

- Ian Powell, Executive Director and advocate
- Angela Belich, Deputy Executive Director and co-advocate
- Hein Stander, National President and Tairawhiti (paediatrics)*
- Julian Fuller, Vice President and Waitemata, anaesthesia*
- Ian Page, Northland (obstetrics & gynaecology)
- Jonathan Casement, Waitemata (intensivist and anaesthesia)
- Julie Prior, Waitemata (emergency medicine medical officer)
- Jeannette McFarlane, Auckland (pathology)*
- Brigid Connor, Auckland (radiology)
- Julian Vyas, Auckland (paediatrics)
- Willem van der Merwe, Auckland (emergency medicine medical officer)
- Carolyn Fowler, Counties Manukau (anaesthesia)*
- Helen Frith, Counties Manukau (anaesthesia)
Jeff Hoskins, Waikato (anaesthesia)*
Paul Wilson, Bay of Plenty (anaesthesia)*
Angela Freschini, Tairawhit (anaesthesia)
Tim Frendin, Hawke's Bay (geriatric medicine)*
Kai Haidekker, Hawke’s Bay (radiology)
Jeff Brown, MidCentral (paediatrics)*
Neil Stephen, Hutt Valley (dentistry)
Justin Barry-Walsh, Capital & Coast (psychiatry)
Sinead Donnelly, Capital & Coast (palliative medicine)
Andrew Munro, Nelson Marlborough (emergency medicine)
Prieur du Plessis, Nelson Marlborough (orthopaedic medical officer)
Murray Barclay, Canterbury (gastroenterology)*
Seton Henderson, Canterbury (intensivist)*
Anja Werno, Canterbury (microbiology)
Matthew Hills, South Canterbury (medicine)
Tim Mackay, Southern (dentistry).
*National Executive

Any proposed settlement will be taken back to all DHB-employed members (most likely with a recommendation from our negotiating team to either accept or reject) to consider in an indicative secret ballot. The final decision whether to ratify or not the proposed settlement will rest with the National Executive after taking into account the results of the ballot.

**DHBs**

The DHB team comprises:
- Donna McGarvey, advocate DHBSS (the DHBs shared service agency, which usually provides their advocacy services)
- Stephen Gray, co-advocate, DHBSS
- Sam Bartrum, Northland (service manager)
- Beth Bundy, Counties Manukau (human resources)
- Brett Paradine, Waikato (chief operating officer)
- Jenny Martelli, Lakes (service manager)
- Anne Amoore, MidCentral (human resources)
- Michael Frampton, Canterbury (human resources)
- Christine Nolan, South Canterbury (chief operating officer).

This team reports to a little known national body established by the DHBs called the Employment Relations Strategy Group (ERSG). It has no particular legal status; it is simply an internal committee set up by the DHBs to handle employment relations on a national level and collective
agreement negotiations. ERSA includes four chief executives from each of the four regional groupings of DHBs, and the heads of the national bodies of chairs, chief operating officers, chief finance officers and human resource managers. The four chief executives are Julie Patterson (Whanganui), who chairs it, Nick Chamberlain (Northland), Helen Mason (Bay of Plenty) and Carol Heatly (Southern).

In between days of negotiations (and possibly during) their negotiating team will interact with the ERSG over various matters, including updating progress and any mandate questions. Any proposed settlement will require the approval of ERSG but in the form of a recommendation to the chief executives national group which has the authority to ratify a settlement.

**ASMS claim**

The focus of the claim is to better ensure that DHBs have the wherewithal to provide comprehensive and sustainable patient centred care. It must be emphasised that the claim is precisely that, a claim rather than an outcome. It will be narrowed down and reduced as the process evolves. It is broader in scope than it was in the last MECA negotiations.

The process of developing the claim began with consideration of a draft claim prepared by the Executive Director and our industrial team by the National Executive on 4 February, further consideration in a planning session by our full negotiating team on 8 April and then confirmation by the National Executive on 14 April. The original draft claim was further fine-tuned at each of these three stages.

The Employment Relations Act provides a maximum of 36 months for the term (the trigger for renegotiation). Our claim is for 12 months but this is more of a pro forma nature and we have been explicit to the DHBs that we are receptive to a longer term depending what is in the second and possibly third years. This might be, in part, spreading out the impact of some of our specific financial claims over a longer period. The term will be resolved at the same time as salaries and other significant cost issues are.

In summary the claim includes:

**Remuneration**

**Base salary scales**—In the context of a 12 month term, our claim for both the specialist and medical/dental officers to both scales is simple. In effect the current step one is deleted and each step translates to one step number less than the current step. That is, for the specialist scale, Steps 1-2 translate to the new Step 1 (current Step 3) and the current Step 12 translates to Step 11 (current Step 13). The net increase is equivalent to the margin between one’s current step and the next one above. For example, if the margin between one’s current step and the one above is $5,000, then this would be the salary increase. The same principle applies for the medical and dental officer scale, except that it is a 12-step scale.

Given the concentration of members on the top of the respective scales (38% for specialists and 48% for medical & dental officers) and the importance of retention, new 15-step scales are proposed (three additional steps for specialists and four for medical & dental officers as the latter did not receive the additional step in the last negotiations, which has been a source of contention). The claimed margins between the additional steps are the same as the margin
between the current penultimate and ultimate steps.

**Transfer from medical officer to specialist scale**—It is currently permissible for DHBs to place experienced medical and dental officers on the specialist scale. Historically this has occasionally happened, but there is no express provision in the MECA referring to this. The claim seeks to make this transparent and allow a good case to have fair consideration.

**Rates for hours worked on after hours’ call and shifts**—Currently the rate for hours worked on after-hours’ call (average) and shifts (actual) is time-and-a-half (T1.5) except for Waitemata (T2) and Bay of Plenty (T3 of Step 3). Our claim is to increase T1.5 to T.2.

**Superannuation**—This seeks to increase the superannuation subsidy by 3% to the current Australian standard of 9%.

**New clauses**

**Minimum standards for patient centred care**—This is a proposed new clause requiring the development of minimum standards necessary for providing patient centred care in services and departments. It includes using the best evidence available to assess the patient need for best practice care in their geographical area and speciality. This would also include an assessment of the minimum requirements to provide after-hours call and cover for leave that is safe for both patients and employees. Minimum standards of resources include SMO and other staffing, equipment and accommodation. An existing dispute resolution process in the MECA covering patient safety (Clause 41) would be used if agreement between SMOs and their DHB can’t be reached.

**Well-being**—ASMS is seeking an express acknowledgement that the emotional, physical, psychological and spiritual well-being of employees may affect the efficient and effective delivery of health services, patients’ treatment outcomes, patient safety, employees’ ability to meet the accepted professional standards of patient care and employees’ clinical practices generally. Further, we seek agreement that reasonable steps to protect and enhance employees’ well-being will be taken.

**Leave**

**Retention leave**—Long service leave (four weeks after 20 years’ service) was a national provision that has been gradually eroded and changed since the early 1990s. In some of the predecessors of DHBs it was traded off for an increased annual leave, and in others it was reconfigured in entitlements along the lines of two weeks every 10 years, which were then protected when the first MECA (2003-06) was negotiated. They remain protected in Schedule 3 of the MECA – 10 out of the 20 DHBs plus the Southland part of Southern DHB. The claim seeks to extend the best of these protected entitlements to all DHBs and to rename it more appropriately as ‘retention leave’.

**Onerous duties leave**—This was a national provision first negotiated in 1989. It provides for additional leave of up to five days where duties have been exceptionally onerous over the past 12 months. Over time, after the shift away from national negotiations from the early 1990s, this provision tended to be removed as annual leave gradually increased. Schedule 4 contains the remaining provisions that were in force when the first MECA was negotiated. The claim endeavours to extend the provision to all DHBs.

**Paid parental leave**—ASMS is seeking to increase the paid leave entitlement from 6 to 18 weeks,
consistent with the change in the Parental Leave Act. The current 6 weeks entitlement does not absorb any of the statutory entitlement which is set at a standard (lower) rate and administered by the Department of Inland Revenue. The claim also removes the obligation of members to pay back part of the paid leave in the event that they resign from their employment without first returning from leave to work.

Professional development and education

CME expenses—The level of CME expenses ($16,000) has not increased since January 2009 (when it was doubled) although ASMS has not subsequently claimed for increases because many members were not spending the full entitlement. Over time, however this is inevitably changing. Further, increasing sabbatical take-up is having an impact. Consequently we are seeking a $4,000 increase over the term of the next MECA. We are also seeking an increase by $500 to $1,000 for those members who are in a second specialty/MOPs programme.

Secondment—This provision is separate from continuing medical education leave and sabbatical. Currently there is a high degree of managerial discretion over a guideline of secondments of two weeks every three years. The claim seeks to make this an express entitlement.

Time-in-lieu—The MECA currently provides an entitlement for time-in-lieu days for members who undertake approved CME or professional development activities. The claim seeks to extend this to approved CME undertaken on usual non-working week days. For example, emergency medicine doctors working 10-hour four day shifts taking approved CME on the fifth non-DHB week day.

Rights and responsibilities

Protection for new appointees after the expiry date—Under statute, the obligation to offer the MECA to new appointees after the expiry date continues for 12 months. In the last settlement we negotiated an agreed letter between the DHBs and ASMS to continue this protection beyond this 12 months until a replacement is negotiated. The purpose is to protect new appointees from being offered terms and conditions of employment inferior to the MECA. ASMS is seeking to include this additional protection in the MECA.

Recovery time—The claim seeks to establish a mandatory but non-prescriptive, negotiating capacity for those working after-hours shifts and rosters for agreed breaks and rest periods.

Vacancies and locums—ASMS wants to (a) add RMO vacancies as a trigger (in addition to SMOs) for when locums are required to cover vacancies and (b) strengthen the obligation to address the effects on workload of vacancies.

Shift work

Existing shift agreements—The claim seeks to address concerns where shift arrangements have developed in the absence of a negotiated agreement, either inadvertently or deliberately.

Commencement of after-hours shifts—The MECA states that after-hours shifts commence from 7pm. The claim seeks to bring this forward to the more realistic time of 5pm.

Extra week’s leave for shift work—Clause 23.5 of the MECA is based on a provision that applied when medical officers ran emergency departments and provided for a week’s annual leave for those on shift work. Currently this only applies to a small number of DHBs. The claim seeks to make it (a) simpler and (b) applicable to all SMOs working in all emergency departments.
Negotiations on 5-6 May

The ASMS team comprised Ian Powell, Angela Belich, Hein Stander, Julian Fuller, Ian Page, Julie Prior, Julian Vyas, Willem van der Merwe, Helen Frith, Carolyn Fowler (first day only), Jeff Hoskins, Paul Wilson, Angela Freschini, Tim Frendin, Jeff Brown (first day only), Neil Stephens, Sinead Donnelly, Prieur du Plessis, Andrew Munro, Murray Barclay, and Matthew Hills. The DHBs team comprised all but one of their team (Brett Paradine was on pre-arranged leave).

Despite some tension at the end of the first day, the atmosphere was good natured. There was some constructive discussion on a limited range of issues but the DHB team made it clear they were not interested in anything that might encroach upon managerial prerogative. This included dismissing our specific claims on minimum standards for patient centred care, SMO well-being, recovery time and shift work. The ASMS team considered their response to be trivialising.

The DHBs have proposed some wording changes to the current MECA clause on investigating clinical practice (42), which we have agreed to consider. We are giving thought to whether this matter should be dealt with at the negotiating table or in separate technical discussions.

Their approach has been to try to draw us into revising our claim on the funding allocated by the chief executives for this settlement; in other words, the kind of negotiations one has when one is not negotiating.

We have refused to go down this path and instead have recommended that they come back to us when we resume negotiations on 20 May with a proposal responding to each of our specific claims (which they have yet to do aside from the four issues mentioned above) but in the context of a three year term. They have agreed to consider this but not committed to do it.

Kind regards

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